Insurance Authorization & Assignment of Benefits

Financial Responsibility
I have read, understand, and agree to Sonika Gupta MD PLLC's Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Sonika Gupta MD PLLC for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Sonika Gupta MD PLLC to:

1) Release any information necessary to insurance carriers regarding my illness and treatments

2) To process insurance claims generated in the course of examination or treatment

3) To allow a photocopy of my signature to be used to process insurance claims.

This order will remain in effect until revoked by me in writing.

I have requested medical services from Sonika Gupta MD PLLC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original

_____
Patient Name or Parent/Legal Guardian

_____ _____
Patient Name or Parent/Legal Guardian Signature **Date**